Spring Tree Counseling
1007 Church Street • Suite 302 • Evanston, IL 60201
233 E. Erie • Suite 607 • Chicago, IL 60611
Office: (847) 492-1938 Fax: (847) 423-5670

Client History

(Please complete for each attending person.)

Client's Name: ____ Date: ______________

Person Completing Form: ____
Relationship to Client: ____

GENERAL INFORMATION
Marital Status (circle one):
Single / Engaged Married Separated Divorced Widowed

Are you a student? Yes__ No__ Where? ______________________Studying what?_______________

Employed? Yes__ No__ Full Time/Part time _________Employment Date______________________
Employer ____
Occupation ____

PRESENTING PROBLEM
Please state in your own words the main reason for seeking counseling.
____
____
____

On the scale below, please estimate the severity of your problems:

Mildly	Moderately	Very	Extremely	Totally
Upsetting____	Upsetting____	Upsetting_____	Upsetting____	Upsetting____

Have you been in counseling before or received any professional assistance for these or other problems? If so, please give names, professional titles, dates of treatment and results.
____
____
____

Have you ever attempted suicide? Yes___No___

Have you ever been hospitalized for psychological problems? Yes___No___ If yes, when and where?
____
____

PERSONAL AND SOCIAL HISTORY

Please list all of immediate family members, including, parents, siblings, spouses, and children. For those deceased, please give date and cause of death.

Name	Relationship	Sex (M/F)	Age	Living / Deceased	If Deceased, Date and Cause of Death

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

__Affectionate __ Aggressive __ Avoidant __Fight/argue often __Follower Friendly
__Leader __Outgoing __Shy __Submissive __Other (specify)

Sexual orientation: ________________ Comments: ____

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? ____

Are you experiencing any problems due to cultural or ethnic issues? __Yes __No

If Yes, describe: ____

Other cultural/ethnic information:____

SPIRITUAL / RELIGIOUS

How important to you are spiritual matters? __Not at all__ Little __Moderate __Much

Are you affiliated with a spiritual or religious group? __Yes __No

If Yes, describe:____

Would you like your spiritual/religious beliefs incorporated into the counseling? __Yes __No

If Yes, describe: ____

SYMPTOMS
Please check how often these symptoms occurred *in the last six months*. If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms *in the last six months*.

Symptom	Never / Rarely	Few times / month	Nearly every day	Symptom	Never / Rarely	Few times / month	Nearly every day
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving house				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heart beat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Over eating				Drug use			
Food preoccupation				Stomach problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self or others			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			

MEDICAL ISSUES
Medications or other medical issues (allergies, thyroid, diabetes, etc.) we should know about:
____
____
____